



DEPARTMENT OF HEALTH & MENTAL HYGIENE

MEDICAL CARE PROGRAM

COMPANION GUIDE FOR 837 HEALTH CARE CLAIM INSTITUTIONAL ENCOUNTERS VERSION 005010X223A2

November 1, 2011

Version 2.1

Health Care Claim Institutional Encounter - 837

Introduction:

This Companion Guide contains a subset of the data content established for the Health Care Claim Transaction Set (837). This transaction can be used to submit health care claim / encounter billing information from providers of health care services to Maryland Medicaid, either directly or through an intermediary (i.e., clearinghouses, etc.).

This Companion Guide governs electronic billing of institutional services on an ASC X12 837- Institutional (005010X223A2) transaction. Please refer to Maryland Medicaid Billing Instructions for specific services to be billed using this transaction.

This guide is not to be used as a substitution for the 837 Health Care Claim Implementation Guide (IG). The objective of this document is to clarify what information is needed by Maryland Medicaid where multiple values exist and specific values are needed.

All alpha characters must be in upper case. Data must be in ASCII format. Leading zeros for data elements such as Provider Number, Recipient ID, must not be suppressed. These data fields should be handled as alphanumeric. Transactions not complying with ASC X12N formatting or data compliance will be rejected prior to adjudication. An ASC X12N 997 or 999 transaction will be used to convey the rejection and may include an associated reason. The Trading Partner will have the choice of receiving either a 997 or 999 acknowledgment transaction.

Always use the 2000B Subscriber Loop (Subscriber Hierarchical Level), since for Maryland Medicaid, the Patient is always the Subscriber.

Please note that the maximum number of service lines per claim is 50. Encounters containing up to and including 50 line items will be adjudicated. Encounters containing more than 50 line items will be accepted but denied before adjudication.

277CA – Claims Acknowledgment Usage

With the release of version 005010 and the changes to the 835 transaction, DHMH will generate a 277CA to handle any rejected and/or suspended claims that were submitted in an 837 transaction. Please refer to the DHMH *Companion Guide for 277 Health Care Claim Acknowledgment Version 005010X214* for details on usage and DHMH specific data requirements.

HI Segment Mapping Clarification

The following provides clarification for mapping HI segments where the occurrence is 2 (or more). In instances where the HI segment occurs 2 (or more) times, it is required that all Data Elements (DEs) of the first occurrence of the HI will be used. In most cases, this provides up to 12 DEs to use to convey the appropriate information for that HI instance. For example:

Correct Mapping: HI*BH:42:D8:20041123*BH:25:D8:20020719

Incorrect Mapping: HI*BH:42:D8:20041123
HI*BH:25:D8:20020719

DHMH will only map DEs within the first HI segment and requests that any needed information to adjudicate a claim is made available in the first HI segment instance.

ICD-10 Implementation

Trading Partners are advised that Maryland Medicaid will not process ICD-10 prior to October 2013. Trading Partners and providers will be provided details on the migration prior to October 1, 2013.

Transmission Considerations

Trading Partners are requested to follow the 837 Implementation Guide recommendations to limit the number of CLMs within a transaction (ST-SE envelope) to 5,000. (See section 1.3.2 of the 837 Institutional Implementation Guides) In cases where the Trading Partner needs to transmit several 5000 CLM files, DHMH recommends uploading the files one at a time in five minute intervals to avoid file submission problems.

Trading partners are requested to use unique Group Control Numbers (GS06) for all interchanges submitted to DHMH. This provides ease of tracking for the Trading Partner for reconciliation, easy identification for DHMH support staff for troubleshooting, identifying Functional Acknowledgements and verifying results.

This Companion Guide can be found on the State of Maryland Department of Health and Mental Hygiene Web site at:

<http://www.dhmf.state.md.us/hipaa/transandcodesets.html>

Maryland Medicaid Companion Guide - 837 Institutional Encounter

LEGEND:

SHADED rows represent "segments" in the X12N implementation guide

NON-SHADED rows represent "data elements" in the X12N implementation guide

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.3			Interchange Control Header			
C.4		ISA01	Authorization Information Qualifier	00		
C.4		ISA03	Security Information Qualifier	00		
C.4		ISA05	Interchange ID Qualifier			Agreed upon during trading partner set-up

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
C.4		ISA06	Interchange Sender ID			Agreed upon during trading partner set-up
C.5		ISA07	Interchange ID Qualifier	ZZ		
C.5		ISA08	Interchange Receiver ID			526002033MCP - Production 526002033MCPT - Test
C.6		ISA14	Acknowledgment Requested	0		No TA1 returned. Note: A 997 or a 999 will be returned.
C.6		ISA15	Usage Indicator			T for Test Data P for Production Data
C.7			Functional Group Header			
C.7		GS02	Application Sender's Code			Agreed upon during trading partner set-up
C.7		GS03	Applications Receiver's Code			MMISENC
C.8		GS08	Version/Release/Industry Identifier Code			005010X223A2
71	1000A		Submitter Name			
72		NM109	Submitter Primary Identifier			Same as GS02
76	1000B		Receiver Name			
77		NM103	Receiver Name			Maryland Medical Care Program
77		NM109	Receiver Primary Identifier			526002033MCP
84	2010AA		Billing Provider Name			
86		NM108	Identification Code Qualifier	XX	2	
86		NM109	Identification Code		10	National Provider ID
94	2010AB		Pay-to-Address Name			Pay-to information sent in this loop will not be used for adjudication. The Pay-to information on file at DHMH will be used for adjudication.
112	2010BA		Subscriber Name			
113		NM108	Identification Code Qualifier	MI	2	

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
114		NM109	Subscriber Primary Identifier		11	Patient's Maryland Medical Assistance Number
122	2010BB		Payer Name			
123		NM103	Payer Name			MCO Organization Name
123		NM108	Payer Qualifier	PI	2	
123		NM109	Payer Identifier			Maryland Medicaid assigned MCO Identifier
131	2000C		Patient Hierarchical Level			This loop will not be supported by Maryland Medicaid since the subscriber is always the patient
144	2300		Claim Information			
166	2300	REF	Payer Claim Control Number			Used for submitting Void and Replace Encounters
166		REF01	Reference Identification qualifier	F8	2	Qualifier for ICN to Credit
166		REF02	Payer Claim Control Number		17	ICN to Credit
170	2300	REF	Claim Identifier For Transmission Intermediaries			
170		REF01	Reference Identification qualifier	D9	2	Use when sending additional account number
171		REF02	Claim Number		30	Use for additional account number (Patient Account Number)
449	2410		Drug Identification			This loop will be used to convey NDC information: NDC, Qty, UOM, price paid by the MCO.
449	2410	LIN	Drug Identification			
451		LIN02	Product/Service ID Qualifier	N4	2	Use when sending NDC
451		LIN03	National Drug Code		11	NDC value
452	2410	CTP	Drug Quantity			
452		CTP04	Quantity		10	Quantity amount of drug used. Precision of 3 decimal positions. (i.e. 1234567.123)

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
453		CTP05	NDC UOM Code	F2 GR ME ML UN	2	NDC UOM codes (see IG for values)
454	2410	REF	Prescription Or Compound Drug Association Number			Used only for identifying compound drug ingredients in multiple service lines within the claim.
454		REF01	Reference Identification qualifier	VY	2	Code qualifier for link seq number
455		REF02	Link Sequence Number		50	Use for additional account number (Patient Account Number)
476	2430		Line Adjudication Information			This loop will be used to convey NDC information: Price paid by the MCO to the provider for the NDC in this service line.
476	2430	SVD	Drug Identification			
476		SVD01	Identification Code			SVD01 data element must = 2010BB data element NM109
477		SVD02	Service Line Paid Amount		9	Total NDC amount paid by the MCO to the provider for the NDC in this service line. For a compound drug , send the total NDC amount paid for the compound in all NDC service lines that make up the compound.
486	2430	DTP	Drug Quantity			
486		DTP01	Date Time Qualifier	573	3	Date Claim Paid
486		DTP03	Adjudication Date		8	The date the claim was adjudicated by the MCO for payment to the provider. Format CCYYMMDD